Transcript – Sarah Fox, Class of 1989

Narrator: Sarah Fox
Interviewer: Amanda Knox, Pembroke Center Assistant Archivist
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Amanda Knox: Good afternoon. My name is Amanda Knox. I am the Assistant Archivist at the Pembroke Center at Brown University. It is Friday, April 24, 2020. It's three o'clock in the afternoon and I am here today via Zoom with Dr. Sarah Fox. We are in the middle of a global pandemic, which is why, which is what brought us together today and why we're conducting our interview in this way. So welcome Dr. Fox, would you like to introduce yourself to our listeners?

Sarah Fox: Yes. Thank you for inviting me. So I'm Dr. Sarah Fox. I'm a gynecologist, and I also teach, most years, I teach an undergraduate class at Brown in reproductive health. And by chance I ended up not teaching this year, but I am also a Clinical Assistant [1:00] Professor in the Surgery Department at the Alpert School of Medicine. I also run the Pelvic Pain program at the Women's Medicine Collaborative and that's kind of my passion project.

AK: So I have a lot of questions for you today, particularly in terms of women's health, and all of these interviews are, are COVID-19 through generally a women's perspective, but I kind of want to start from the beginning. Do you remember the first time that you heard COVID-19 or Coronavirus? And what were you thinking or feeling when, when you were starting to hear about this?

SF: So I started following it very early on. I don't remember if it was December or January, but as soon as it was happening in China, I was watching the daily like, curving increase of the number of [2:00] cases in China and the number of deaths. And my first thought when I saw this huge uptick was, this is not going to stay in China. I still didn't know that it was going to be quite as widespread as it is, but I knew that it was coming. And I have to say, by January I was already stocking up on non-perishables.

AK: Well, that was my next question is, I, I am kind of interested in these interviews seeing the perspective of a doctor compared to other people. So what, you, you might have known more what kinds of things to stock, stock up on than like an average person, for example, but what kinds of things were you getting? And again, kind of feelings, what were you kind of feeling or thinking as you were starting to stock up on things? [3:00]

SF: So every time I went to the grocery store, I would just buy a few items. And you know, extra, and then I put them in a big box in my closet. And I did that over several months. And I would kind of think about what I already had and try to balance it and get different kinds of foods. And I did get a couple of things of toilet paper and I didn't hoard it, but just, you know, a little extra thing here or there. And then it wasn't until about, I guess it was March that I started rummaging through, because I knew somewhere in my house I had two N95 masks from when I had been the point person at my office for the Ebola outbreak that never was an outbreak.

AK: Yeah.

SF: But I knew I had two N95s. So it was early March that I started [4:00] rummaging and found those.

AK: So at what point, I'm going to assume there was a point where you thought this is crazy serious. At what point were you having that thought where it was becoming clear that this was probably more than what we imagined it was going to be here in the United States.

SF: I think certainly by the time we had a few cases in Seattle. You know, by then I knew it was going to be really bad because we weren't prepared. We weren't doing anything. There was no coordinated effort. And I think in part, it was so different from Ebola. You know, Ebola was, as a disease, terrifying because if you got it, it was so uniformly serious. No one got away with an easy case of Ebola. But the, [5:00] you know, the, the coordinated response from the federal government was so different. You know, our, our training in Rhode Island was led by the CDC [Centers for Disease Control]. You know, and so we were getting the same information as they were getting in Texas, or Florida, or California. And it seemed to be organized and coordinated.

And if you needed the PPE [personal protective equipment], you put in an order and you received the PPE. And you know, and at that point, it was clear that we had no unified response. It was just chaos. And that was when I realized that things were going to get really, really bad.

AK: Were you, do you physically, you're physically on the Brown campus under normal circumstances, right?

SF: So when I teach I am. And just, I was trying to [6:00] figure out a way to kind of revamp the class this year and I just didn't have time to do it. And so I haven't been teaching and I really haven't been up on campus that much. I was up on campus in the fall, but not at all this spring.

AK: Were you following any communications out of Brown? And I guess, generally my larger question is, do you have any thoughts or were you having any feelings based on communications that were coming out of Brown in the days leading up to Brown going completely online?

SF: I, you know, it's funny. I don't have, I wasn't following the Brown updates. I was then following the updates from my hospital and my office, the Rhode Island Department of Health, and then just general like both the, you know, the medical [7:00] literature and things from the CDC, and then newspapers. So I've been following it pretty closely. I haven't followed Brown, like the, the on campus info, but I did make a trip to the Brown campus. I wish I had looked it up to find out when it was, it was when I already knew that things were very, very bad. And I was meeting with a few other faculty members who were all still shaking hands. And it was quite, you know, they came over to shake my hand and I said, "No, I'm not shaking hands because of the coronavirus." And they kind of looked at me and I thought, "What world are you, you're living in a different world than I am." Because I would, you know, I have to say, I, I've stopped shaking hands for the most part even before this, but with this, I completely stopped.

AK: Yeah, that's interesting because it came up in an interview I had just done an hour ago. [8:00] Kind of these awkward moments. And I remember for me also in the beginning where people are like, "Well, I'm going hug you. You don't mind right?" And then they kind of go in for the hug and you don't want to be an alarmist, but you also want to take it seriously. And it

was like, ah! So it's, it's interesting how long it was taking people to, to kind of end that, that habit. What kind of day-to-day changes, or any changes at all, did you start seeing at your hospital as, as this was starting to grow here? Or even maybe before?

SF: So I have to give total kudos to my hospital. Rhode Island Hospital and Lifespan. They have done an amazing job. [cell phone ringing] Sorry, I guess this is part of the Zoom world.

AK: Yes. Exactly.

SF: There won't be any dogs or kids on this one, but we've got the phone. So, so anyway, [9:00] they've done such an amazing job both with communications and coordination. And you know, and, and that's been really a wonderful thing. But the first thing that happened for us is that we were told to stop all non-essential visits. And so as a gynecologist, it's really hard to figure out what's a non-essential visit. You know, if someone's uncomfortable, but it's not going to kill them. Do you leave them at home uncomfortable? Do you just start calling in prescriptions when you may not know exactly what you're treating? Or things where you know, we follow up a lot with pap smears for example, and there are pap smears where we know, okay, with this particular result, you might have a 10% risk of having a pre-cancer or a cancer and in ordinary times we would get them in quickly and evaluate and make sure there isn't a pre-cancer or a cancer. But what do you do [10:00] now? You know, if that person is healthy, then I probably will still bring them in and assess them. But what if they have pre-existing health conditions? You know, that 10% risk of a pre cancer, which probably is okay in six months, but may not be. And, you know, my biggest question about some of these people with health issues is, are we going to be able to bring them in more safely in six months?

AK: Right.

SF: So that was the first thing we saw. And then we cancelled all the elective surgeries.

AK: So –

SF: And that – go ahead.

AK: Go ahead.

SF: So it was, that was really stressful. You know, I was very fortunate that I was able to get kind of one last little batch of patients through, but I had someone come in yesterday to see me and she was desperate and she said, I need a hysterectomy.

AK: Wow.

SF: And I said, "I'm you know, I'm really sorry." [11:00]

AK: Wow. Okay, so 100 more questions that I just developed. First of all, how have you gone about determining what is an essential appointment and what is not?

SF: So I'm lucky to have a colleague that I practiced with for, it must be about maybe 15 years, and she and I sit down pretty regularly and just do a checklist. Who are you bringing in? Are you still bringing these people in? And when I find someone who has something of consequence, for example, that abnormal pap smear, but who also has health issues, I present it to them and you know, I always, I felt with my practice that the best outcome is going to be if I explain things to patients and let them take part in the decision making. So [12:00] I try to explain to them this is the risk of you coming in, this is the risk of, you know you not coming in, and then allow them to decide, are you more scared of an abnormal pap or more scared of coronavirus? And then I try to put it into perspective. If they're still going to the grocery store, I'm safer than the grocery store.

AK: Right for sure. So can I ask, personally, with, which risk would you take it? Like, if I posed that question to you? I don't know if, you don't have to answer that if you don't want to. But if you do want to, how would you approach that question?

SF: It's interesting you might ask that. I was scheduled for an elective procedure on April 2nd, for myself. And it got canceled. And if they'd let me do it, I would have done it.

AK: Really?

SF: Mh hmm. [13:00]

AK: Wow, okay.

SF: Yeah. And you know, and that leaves me with something that's not life threatening, but it's really unpleasant. And I know it's going to be three to six months before I can get it taken care of. But then there's a whole other piece that comes into play, which is that I had set two weeks aside for my recovery. And I am going to be so far behind with all the people who I've had to cancel or turn into telehealth that there's no way I'm going to get two weeks out.

AK: Yeah. Wow.

SF: So yeah, I was willing to do it, but my surgeon was not.

AK: Interesting. So, the telehealth, I know is something that is probably widespread at this point. Was that something that you were doing before coronavirus or is that something that you've recently started using with your patients?

SF: So this is one of the few things that I am so excited about [14:00] with the coronavirus. I have been trying to get telehealth for years. And the problem is that the insurance companies will not pay doctors for their phone time. So unlike a lawyer who charges you by 15 minute increments, no matter whether it's in person or by phone, if you talk to a doctor for 20 minutes, that's their own time that they're giving you and they do not get a cent for it.

AK: Really?

SF: Really.

AK: Interesting. I had no idea.

SF: Yeah, most people don't. And so, you know, this is something that when you have a patient who has complicated results you need to go over, you know it's going to take 20 minutes, 30 minutes. I don't mind doing that by phone, but if you start stacking up four or five of those, and that's an additional like two or three hours in my day that I'm not getting any revenue for. And again, I'm not doing it for the money, but at the end of the day, you have to pay your staff. [15:00]

AK: Right. Exactly.

SF: So, you know, so this, all of a sudden, all of the barriers were gone. You can do anything by telehealth now. Even most insurances will cover a new evaluation for a new patient you've never seen. You can start the process with telehealth.

AK: Wow, cool.

SF: It's totally life changing. I, you know, I mentioned that I see pelvic pain patients and the barriers to care for them are huge. Some of them will drive 20, 30, 40 minutes to come and see me. And if they're having a bad pain day, they can't drive themselves that distance. So to be able to switch to a telehealth and still have a visit where I can maybe help them through and give them some ideas of how to manage their pain flairs, life changing for them.

AK: Absolutely.

SD: My no-show rate has come way down. We build in kind of a little buffer because you know people are going to not show, [16:00] and everyone shows up because people can be at work, they can pop out for 15 minutes, have a visit, they can sit in their car and talk. People with childcare issues can still have their visits.

AK: Wow.

SF: Yeah.

AK: So do you think that's something that, and this is probably total speculation, but do you think this is something that will be able to carry on if ever there is an after coronavirus life?

SF: I really hope so. I think this is going to go on long enough that people are going to get used to it. And I don't know that the patients are going to be okay with giving that option up because a lot of people really like it. I personally hate talking on the phone. But I'd still rather do this then have people have trouble getting in for an appointment. So to me, I mean, I really hope they continue this. If they do, that would be one good thing that would come out of this.

AK: For sure. [17:00] Do you feel that you're able to make the same, a diagnosis with the same amount of certainty or confidence via telehealth as when someone's in your office? Or is it a very different experience?

SF: It's a, it's a completely different experience, but what I'm using it for in large part is a triage method. So I can talk to them, really get a good idea of their symptoms, and then sometimes you know exactly what you're dealing with. Especially if you know the patient, you know exactly what you're dealing with, you can help them. Other times, I can say to them, "Okay, I do need you to go to the lab, get some lab work done or get an ultrasound," or something like that. But they may not have to come and see me. And then other times, you know, we'll talk on the phone, it won't be clear [18:00] or there's something I need to look at. I have had a couple of people send me pictures through the portal and then we talk by phone. That's okay, too.

AK: Yes.

SF: So, I just started the video telehealth. And so, that may help a little bit with some things. But, but yeah, you know, then I am bringing in usually a few patients per day that I see in person, and then the bulk of the patients are telehealth.

AK: Wow, that's pretty good.

SF: Yeah.

AK: Are there other things that you foresee for the medical profession as being good or bad changes going forward? Or again, in a life after coronavirus, or like back to normal, do you see any significant changes happening to your day-to-day life?

SF: So I think the biggest concern is the toll that this is going to take on [19:00] our healthcare system, you know. I think most, in Rhode Island, most providers are part of a practice that's either hospital based or like a large practice space. And the hospitals are getting, they're really getting hurt by this financially. So the elective procedures tend to be something that they make money on. Things like routine mammograms have all been canceled. That's something that is a financial win for them. Taking care of coronaviruses, patients, is a total financial loss for them, and that's what they're doing now. And Rhode Island has never had a good margin for hospitals or health care organizations. It's a really, really hard market. The reimbursement is terrible in this state. And so I really worry about you know, [20:00] specialty programs like mine. So again, I care for women with pelvic pain, with people with pelvic pain, and primarily women. And one of the things that, that I know is that my hospital believes in my program. I don't make money for them, but I take good care of my patients. And if I didn't do this, they would be in the emergency room and you know, they would be struggling with other providers. So it's a service to the community. It's a service to my colleagues. It's a great service to the patients, I hope, but I don't make any money. So I'm here because the hospital believes in what I'm doing. But if the finances get bad, I worry that they may not have the ability to believe in what I'm doing. So you know, so I'm worried about that piece.

AK: So what you're doing is [21:00] completely foundational to women's health. So what kind of impact have you seen on women's health? And maybe it sounds like you may work with some people in the trans community as well. What kind of impact are you seeing on the health of these people because of the pandemic?

SF: So it's a variety of reactions. There are some people who I work with who have really toxic jobs, and they're working from home and it's actually an improvement for them. Yeah. There are certainly people who have anxiety disorders kind of as a baseline, and this may really be flaring their anxiety. And I definitely am seeing a lot of patients who are working in service jobs and

[22:00] you know, don't have the ability to care for themselves. I saw someone the other day who, you know, works in food services, and she wears her mask, but the people around her don't wear a mask. And so, you know, she's still at risk until they cover their faces. And, and that's one thing that, you know, I really wish that there were a way to make that a little bit more strict. Because even if you don't have a mask, put a bandana over your face, everyone can do that. And that makes a huge difference and I don't know, that's one of the things that bothers me the most about this is this idea that, you know, it's my body, I'm not going to wear a face mask. And the reality is you don't wear it for yourself.

AK: Right.

SF: You wear it because you respect and care for the people around you. And if you're not wearing a mask, then that's kind of giving a [23:00] middle finger to everyone around you. And for me personally, I am slated to go on the front line on May 4.

AK: Wow.

SF: And I'm okay with that. I really am. But for God's sake, wear a mask, you know, don't put me at additional risk. Perhaps if people were wearing more masks, I wouldn't have to go to the front line in a week and a half.

AK: And so to go to the front lines, you're going to be working less on specifically women's health? It's, you're just there to use your doctor brain and fix people.

SF: I'm going to be acting as probably an intern because the last time I did anything with like cardiac and respiratory things was medical school. So I will be working with somebody who [24:00] is more expert in that area, and they will be having me run around and do little basic things to help them out.

AK: And did you volunteer for that or have you been kind of drafted, so to speak?

SF: Well, it was clear that they needed help. And I volunteered because I feel like so many people are making huge sacrifices. And I'm in a situation, I don't have kids, I live alone. You know, I'm not going to bring it home to anyone. And I, you know, I wanted to help out. So yeah, I did volunteer for it.

AK: A couple more questions for you. This one's a little bit broader and kind of more off topic, but what, what do you think has been the hardest thing for you so [25:00] far in the pandemic, either personally or professionally?

SF: The hardest thing was sitting in an exam room with a patient who had a nice mask and she was pulling at it and scratching her face and twisting it. And she said, "I hate this mask," took it off and crumpled it up in front of me.

AK: Oh, no.

SF: And I thought I was going to lose my mind. I looked at her and I said, "Okay. There are people dying because they don't have masks. I want you to flatten that out. And I want you to put it in your purse and take it home and you will use it again." And she looked at me and she said, "I have a whole bunch of them at home." That was the single hardest moment where I had to just say, okay, this is somebody who, like you are not going to get her on the right path. [26:00] She is just one of those jerks. And, you know, I finished up her appointment and yeah, but that that was, that's the hardest part of all of this is just seeing people being so careless when I know that I have colleagues who I mean, I have colleagues who have been sick and almost died from it. I have colleagues who are on the front lines right now. And that's the hardest part.

AK: For sure. I'm, on behalf of all humankind, I'm sorry, that, that that is something you had to experience. It kind of leads me to my other question, though, do you feel, do you feel like you're going to have access to enough PPE to be directly on the frontlines? Do you feel like there's enough safety, maybe at least in Rhode Island hospitals right now, for, for you to do that?

SF: So I can't say all Rhode Island hospitals, but I know that, that [27:00] my hospital has PPE.

They've been really good about making that available. And the other thing is that I get daily updates so I know, you know, how many cases they have in the hospital, how many people are on ventilators, how much of the different supplies they have. Like, they actually tell us how much they have, how many masks they have, how many shields they have, those kinds of things. And so, you know, like, you get a sense of it. And then you know, oh, if they're running short on something, I'm going to start conserving that, and I can be part of this solution. But yeah, I'm not particularly worried about it. Like I said, I have a couple of N95s from the Ebola virus. And I use them over and over again and I'll keep doing that. So you know, and one of my friends did a 3D face shield for me and so I feel like I'll be okay.

AK: Okay. So I don't want to take up [28:00] too much of your time. I guess my last question would be, and maybe the answer is something you've already said, but if someone were to listen to this interview tomorrow, what is one thing you would want them to know? And if someone is listening to this 10 years from now, what is something you would want them to know about this moment that were in?

SF: So I'm glad you asked that. If they're listening to it tomorrow, cover your face. Do not wear your mask underneath your nose. Don't let it hang off one of your ears. Those things are worth their weight in gold. Be careful with them. But always cover your face with something when you go out.

And the 10 years from now, this was not I mean, this was avoidable. This did not have to be this bad. We could have been prepared. We could have been testing from the beginning. You know the missed opportunities of us saying that we're [29:00] not going to take the World Health Organization tests, you know, we lost months on that. The fact that we didn't shut things down quickly. We should have been shutting down as soon as it hit our shores. And it would have prevented all of this pain and suffering. And, you know, the suffering is real, you know, you can look at these numbers and say, "Oh, there are not that many people dying," but you have to remember that this is a horrible, painful disease, and people are going through it alone. Their family members can't be there. And so all of these deaths are happening. These people are alone. It is, it's horrific for seasoned healthcare workers who've seen all kinds of things. This is, this is horrible, but it didn't have to be this bad. And, you know, I'm going to take a political moment

and say, it matters who is president. To have someone competent in that job, you know, I may disagree with some of our past presidents, [30:00] but I don't think any of our past presidents would have let this happen.

AK: Yeah. For sure. I completely, completely agree with you. But, so before we close, is there anything else that you were hoping that I would ask that I didn't ask? Or anything else that you would like to add before we wrap up?

SF: I think the only other thing you know, again, going back to if someone watched this tomorrow, what I would want them to know, your doctors are still there. We are still doing telehealth, we can get on the phone with you. We can help you through things. If you have problems, if you have concerns. And you know, even if you're not safe at home, figure out a way to get us a message. And there are you know, there are lots of organizations doing this work, but talk to us, you know, let us know that you need to come in, we can bring you in, we can help you. So, you know, don't think that we're not here [31:00] just because you're stuck at home. And thank you so much for doing this, this is really an amazing project.

AK: Thank you so much. I really appreciate that you were willing to talk to me today. I thank you for the work you are doing on women's and trans people's health and in the work that you're going to do on the front lines. It's truly brave and I appreciate you doing that for all of us.

SF: Thank you.

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